MANDATORY ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL
HEALTH INSURANCE PREMIUMS WRITTEN
(2003)

*****PLEASE NOTE*****
<u>NEW REQUIREMENT</u>:
<u>All</u> insurers shall submit a <u>complete</u>
copy of their 2003 Arkansas Annual Report
of Premiums, Taxes, and Fees.

<u>All insurers</u>, as a condition of doing business in Arkansas, shall complete the attached information form, <u>including</u> those insurers that do not write, or are not licensed to write, accident and health insurance premiums in Arkansas. Failure to comply may result in a monetary penalty imposed by the Arkansas Insurance Commissioner.

<u>DUE DATE: MARCH 1, 2004</u>

<u>Mailing Address</u>:

Arkansas Comprehensive Health Insurance Pool
P.O. Box 419
Little Rock, Arkansas 72203
(501) 370-2659

<u>Overnight Delivery Address</u>:

Darla Crawford / CHIP
c/o Mitchell, Williams, Selig, Gates
& Woodyard
425 W. Capitol Avenue, Suite 1800
Little Rock, Arkansas 72201
(501) 370-4215 *dcrawford@mwsgw.com*

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HEALTH INSURANCE PREMIUMS WRITTEN
(2003)

INSTRUCTIONS

A. **All insurers, as a condition of doing business in Arkansas, shall complete the attached form, including insurers that do not write, or are not licensed to write, accident and health insurance premiums in Arkansas.**

PLEASE NOTE NEW REQUIREMENT:
All insurers shall submit a complete copy of their 2003 Arkansas Annual Report of Premiums, Taxes, and Fees.

B. Every insurer is required by law to report any **Premiums Written** in Arkansas on the attached form. This reporting requirement also applies to Property and Casualty insurers authorized to write Accident and Health insurance in Arkansas. If you are an insurer that does not write **Health Insurance**, please complete the form by inserting "N/A" in the proper places, and return the form as indicated. Please see DEFINITIONS below.

C. The completed form must be signed by (1) the individual who compiles the information reported on the attached form, and by (2) an Officer of the company certifying that the information provided is true and correct.

D. The original signed form must be returned to one of the following addresses NO LATER THAN **March 1, 2004.**

Mailing Address:
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(501) 370-2659

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& Woodyard. P.L.L.C.
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E. Any QUESTIONS concerning the completion of this form should be directed to any of the following sources listed in paragraph D above: the Mailing Address, either of the telephone numbers, or the e-mail address. Your inquiries will be addressed promptly.

F. **DEFINITIONS**:

(1) "**Health Insurance"** means any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, hospital or medical service corporation, health maintenance organization, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

- **Health Insurance does include**:
  - **(a) Excess or Stop-Loss Coverage**
  - **(b) Medicare Supplement**.

- **Health Insurance does not include**:
  - (a) Long term care
  - (b) Disability income
  - (c) Short term care
  - (d) Accident only
  - (e) Dental only
  - (f) Vision only
  - (g) Fixed indemnity (products such as cancer, long term care, long term disability, and hospital indemnity)
  - (h) Limited benefit
  - (i) Credit
  - (j) Coverage issued as a supplement to liability
  - (k) Insurance arising out of workers' compensation or similar law
  - (l) Automobile medical-payment insurance
  - (m) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance
  - (n) Federal Employee Health Benefits
  - (o) Medicare+Choice (42 CFR § 422.404).

(2) "**Premiums Written**" means premiums written for **Health Insurance**, including **Excess or Stop-Loss Coverage**, covering Arkansas residents. This also includes any "run-off" premiums which have been collected during the past year.

(3) "**Excess or Stop-Loss Coverage**" means an arrangement whereby an insurer insures against the risk that any one (1) claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount. Please note that "Excess or Stop-Loss Coverage" is not reinsurance coverage under Arkansas law.

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*****THIS FORM IS DUE MARCH 1, 2004*****

COMPANY NAME_____

MAILING ADDRESS_____

NAIC GROUP CODE:_____ NAIC COMPANY CODE: _____ TAX ID#:_____

FOR THE YEAR ENDING DECEMBER 31, 2003

1. Total 2003 **ACCIDENT & HEALTH** Premiums reported to Arkansas Insurance Department as shown on Schedule T (for **LIFE** companies) or the Exhibit of Premiums and Losses Page (for **P&C** companies) (including Excess or Stop-Loss Coverage): $_____

Less:

a. Long Term Care $_____
b. Disability Income $_____
c. Short Term Care $_____
d. Accident Only $_____
e. Dental Only $_____
f. Vision Only $_____
g. Fixed Indemnity $_____
h. Limited Benefit $_____
i. Credit Insurance $_____
j. Coverage Issued as a Supplement to Liability Insurance $_____
k. Insurance arising out of Workers' Compensation or similar law $_____
l. Automobile Medical Payment Insurance $_____
m. Insurance under which benefits are payable with or without regard to no fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance $_____
n. Federal Employee Health Benefits $_____
o. Medicare+Choice (42 CFR § 422.404) $_____

2. **Balance** – Health Premiums Reportable to CHIP (Line 1. , minus 1.a. – 1.o.) $_____
3. Of the BALANCE reported on Line 2., please provide a BREAKDOWN as follows:
   a. Group/Individual Policies (including Conversion Policies) $_____
   b. Excess or Stop-Loss Coverage $_____

CONTACT INFORMATION

1. Name/Title of Person Compiling Information:

X _____

2. Telephone:_____

3. E-mail:_____

COMPANY CERTIFICATION

I hereby certify that the foregoing information is true and correct.

X _____
Signature of Company OFFICER

_____
Typed Name/Title of Company OFFICER